

KENTUCKY BOARD OF LICENSURE FOR MASSAGE THERAPY

P.O. Box 1360, Frankfort, Kentucky 40602 ~ 911 Leawood Drive, Frankfort, Kentucky 40601 (502) 564-3296, ~ http://bmt.ky.gov

UNLICENSED ACTIVITY REPORT

INSTRUCTIONS

- 1. This form must be typed or printed legibly and completed in its entirety.
- 2. Attach continuation sheets if more space is needed to provide information.
- 3. Refer to 201 KAR 42:050
- 4. This completed form may be submitted to the Kentucky Board of Licensure for Massage Therapy either by mail to P.O. Box 1360, Frankfort, KY 40602 or by delivery to 911 Leawood Drive, Frankfort, Kentucky 40601.

PERSON FILING COMPLAINT

Complainant Name				Date of Complaint
Street Address		City	State	Zip Code
Home Telephone Numb	oer	Cell Telephone Number		Email Address
☐ I prefer to remain a	inonymous.			
	OFFENDIN	G INDIVIDUAL AND / OR BUSIN	IESS	
Name				
Street Address		City	State	Zip Code
Home Telephone Number		Cell Telephone Number		Email Address
		ID PHONE NUMBER OF PERSO ROVIDE ADDITIONAL INFORM		
Name		Relationship to Comp	lainant	
Telephone Number	Email Address	Email Address Type of Additional Information to be Provided		
Name	e Relationship to Complainant			
Telephone Number	Email Address	Type of Additional Info	ormation to be Pro	vided
Name		Relationship to Comp	lainant	
Telephone Number	Email Address	Type of Additional Info	ormation to be Pro	vided

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BRIEF SUMMARY OF COMPLAINT

Please be specific as possible regarding names, dates, locations, and action which you believe unlicensed activities occurred. Please attach copies of any documents or records pertinent to your complaint.

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CERTIFICATION				
I certify that the information provided on this form as submitted to the Kentucky Board of Licensure for Massage Therapy is true and correct in its entirety.				
Complainant Signature Date				

FOR OFFICE USE ONLY			
Date Received:			
Case Number:			
LMT License #:			
Date Closed:			

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